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# A PREMIUM PRICE: THE HIDDEN COSTS ALL CALIFORNIANS PAY IN OUR FRAGMENTED HEALTH CARE SYSTEM

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Health insurance is the primary method Californians use to access and pay for health care. However, millions of Californians have inadequate health insurance or lack coverage entirely. When care is needed, the first inclination for these families is to delay treatment that it is too costly and then hope for the best. And when hope is not enough, these families are forced to seek treatment that they often cannot afford.[1] When medical bills go unpaid, many health care providers shift the costs onto those who can pay—those with health insurance.

This cost-shifting amounts to a hidden tax levied by providers on behalf of those who cannot pay, the uninsured and underinsured. In our poorly designed health care system, providers have little choice but to shift costs. This results in an approximate 10 percent increase in health insurance premiums for Californians. More specifically, the average California family with health insurance will pay an additional $1,186 in premiums for 2006. Individuals purchasing insurance will spend about $455 annually in additional premiums.[2]

To fix California's broken health care system, the New America Foundation has proposed a system of universal coverage based on shared responsibility of costs among the government, employers, and individuals.

### *California's Uninsured*

In 2003, more than 6.5 million Californians were uninsured at some point.[3] Of these, more than two-thirds work in full-time jobs.[4] Young adults are the most likely to be uninsured in California; more than 30 percent of those between ages 18 and 34 live without health insurance coverage.[5] More than three in five of the uninsured earn less than 200 percent of the Federal Poverty Level (FPL, $33,200 for a family of three in 2006), while more than one in five uninsured are in families making more than 300 percent FPL ($49,800 for a family of three).

It is well documented that the uninsured live sicker and have shorter lives.[6] Compared to the insured, they do not receive the same amount or quality of care.[7] This is true despite the fact that the uninsured generally pay a higher percentage of their income for health services out-of-pocket than those with insurance.

### *Health Care is Not Free*

The first step to understanding the hidden "cost-shifting" tax is to understand that health care providers must be compensated for their services. It is an economic truth that, under any market system, those who can pay more will have better access to what they want. Nevertheless, given the life-saving potential of timely health care, access to care is sometimes granted for those who cannot pay. An unpaid health care bill is technically referred to as "uncompensated care," meaning the provider is unpaid by the patient or the insurer. As California's health care costs continue to skyrocket, uncompensated care rates will continue to grow.

To varying degrees, all hospitals and physicians provide some care for which they are not paid directly. In fact, Federal law requires hospital emergency rooms to stabilize patients regardless of their ability to pay. This reflects our social unwillingness to sanction gross denials of care based on income, and in part, makes emergency rooms the providers of last resort for all Americans.

Many hospitals—especially public hospitals and some non-profit hospitals—have long traditions of providing all the care their patients need, regardless of ability to pay. Community health centers also provide medical services and charge patients on a sliding scale, usually raising far less in patient fees from the uninsured than their health care actually costs. After all, the main reason most uninsured stay uninsured is that they cannot afford health insurance or the price of retail health care.

Providers do not have unlimited pockets to secretly finance the health care provided to millions of uninsured (and underinsured) patients. Hospitals and physicians anticipate the fact that the uninsured will seek care each year. They prepare for this reality by:

- Setting prices for the insured that are higher than expected costs.
- Cultivating supplemental funding streams (e.g., charitable contributions, and state/Federal grants that partially compensate them for treating the uninsured, etc.).
- Planning to accept lower revenues than they could otherwise earn.
- Seeking redress in bankruptcy court for past unpaid bills.

Like any business facing a loss, providers must turn elsewhere to cover costs when care is uncompensated. "No margin, no mission" is an adage that has long been applied in health care institutions, including non-profit hospitals, meaning that an organization must have sufficient revenues to continue operations.

***Calculating Hidden Costs of the Uninsured: Explanation and Methodology***

In this section, we discuss the methodology for determining the portion of the average privately insured family's premium that is actually used to cover the cost of the uninsured.

In 2006, approximately 8 percent of health spending in California is devoted to the uninsured, or about $16 billion. This conclusion is based on the multiplication of two factors.[8] First, roughly 20 percent of Californians are uninsured, as cited above. Second, the uninsured receive less care than the insured.[9] In California, the best estimates are that the average uninsured person gets less than 40 percent of the care received by the average insured person.[10] This is lower than the national average of 50 percent.[11]

Of this total spending on the uninsured, California's uninsured actually pay for 40 percent of costs out of their own pocket. This is based on national and California studies that show the full-year uninsured can spend 30 to 50 percent out of their own pockets for health care, depending on age and other factors.[12] Assuming a midpoint of 40 percent for out-of-pocket spending, there is still 60 percent of spending (or $9.6 billion) to be financed in some other way.

To help defray the remaining $9.6 billion,[13] state, Federal and local governments spend several billion dollars annually. Yet even the largest programs in California only offer $2 billion toward this need. Also, these additional funds have a dual purpose of defraying the cost of the underinsured (see next section). We believe, on balance, the bulk of the $9.6 billion in uncompensated care costs are shifted to private payers.

We conservatively estimate that about 10 percent of California health care premiums can be attributed to cost-shifting due to the uninsured.[14] This means that cost shifting inflates the average annual premium for a California family by $1,186. Individuals purchasing policies pay an additional $455 annually in higher premiums.[15] These figures are derived from assuming the amount to be shifted (4.8 percent of total health spending) is extracted from private payers (who we conservatively estimate to pay as much as 55 percent of total spending).[16]

Our estimate is slightly higher than other estimates of the national average cost-shift because the percentage of the population covered by private insurance—wherein providers have some ability to influence payment rates—is lower in California (55 percent) than the national average (58 percent).[17] This means the required health spending must be extracted from a smaller base. Our estimate is conservative for the same reason. Nationally, private payers finance 55 percent of total spending. There are no recent comparable estimates for California alone. Since the privately insured population is a smaller fraction of California's population, it is highly probable that private spending is less than 55 percent of total spending. This makes the uninsured tax rate even higher.

***Cost-Shift to the Insured: Underinsured Explanation and Methodology***

Thus far, our analysis has only considered the impact of the uninsured. It has yet to address the possible cost-shift from the underinsured, individuals and families with coverage policies that do not cover

what they actually need or that restrict provider payments to levels that are below actual cost. However, it is difficult to quantify precisely the impact of the underinsured precisely because of a lack of data surrounding the relationship between indirect government spending on health care and the actual cost of services provided to the uninsured and underinsured. As the following demonstrates, there is reason to believe that the underinsured, particularly in California's government programs, contribute significantly to cost-shifting, thereby adding even higher costs to private premiums.

This confusion on underinsured payments becomes clear when one considers the suggestion that as much as 85 percent of the costs incurred on behalf of the uninsured and underinsured are paid for by a combination of governmental subsidy programs.[18] However, it is unlikely these programs defray even the costs of serving the uninsured, let alone the costs of care for the underinsured. This 85 percent estimate includes a variety of programs, such as Medicare and Medicaid disproportionate share payments (DSH),[19] Medicare's Indirect Medical Education (IME),[20] Veteran's Administration (VA) plus Indian Health Service budgets,[21] and spending on the National Health Service Corps.[22] Yet, none of the dollars from these programs flow to private physician offices or many hospitals.

Moreover, DSH and IME payments are formally designated as necessary to help fill the well-documented shortfall in public insurance payments for Medicaid and Medicare patients.[23] In fact, a recent national estimate of public sector underpayment by Dobson et al concluded that private payers, on average, pay 22 percent more than their costs to make up for the totality of this public sector shortfall.[24] Public programs are often a source of "underinsurance" in that they pay rates which are significantly lower than those from other payers (i.e. private insurers).

There is every reason to believe that this shortfall occurs in California, just as it does nationally. For example, Medi-Cal, California's version of the Federal Medicaid program that provides subsidized insurance for low-income individuals, pays providers roughly 9 percent less than the national average. These payment rates are lower than 45 other states.[25]

***Implications and Conclusions***

Based on the analysis presented here, our best estimate of an average private sector cost-shift due to the uninsured is likely 10 percent. Given what is known about the underinsured, the total cost-shifting rate is likely much higher. Our fragmented health care system leaves providers little choice but to shift these costs to private payers, and the opaque nature of the health care system hides these costs. These findings have the following important implications.

- *All Californians have an interest in covering the uninsured.* It is too easy for the 80 percent of Californians with insurance to dismiss the uninsured as an issue that does not affect them. Many businesses that offer insurance today have this same belief. However, as this analysis shows, the cost of the uninsured is shared across those who purchase private insurance in a way that hides the true costs. Covering the uninsured is a matter of self-interest for all Californians.

  More importantly, our under-funded and broken health care system puts everyone's health at risk. Uncompensated care means that hospitals and emergency departments face the threat of closure, and it means that the resources needed to provide care are not always available. A better funded health system will make care more affordable, accessible, and stable for all Californians.

- *California's future will be stronger if the uninsured are covered.* Though not a direct part of this analysis, it is worth noting that there is a broad economic interest in covering the uninsured. America's health insurance gap has been estimated to reduce national economic productivity by $65 to $130 billion annually (2003 dollars).[26] It is in California's interest to create a fair financing mechanism so that people have coverage and employers can compete globally. On an individual level, research shows that at least half of all bankruptcies are related to medical costs. Also, insured children are healthier and better ready to learn.

- *An expansion of coverage would help eliminate cost-shifting.* A universal coverage program with comprehensive care and appropriate provider rates would eliminate the need for cost-shifting. Over time, one would expect that at least some of the shifted dollars would be returned to California families in the form of reduced premiums. New America supports a system of shared responsibility—among government, business, and individuals—to cover all

Californians and Americans. Once health insurance is made widely accessible and affordable to all, then all individuals should have the responsibility to obtain coverage. New America's plan released in 2005 to cover all California's uninsured children called for over $1 billion in subsidies to parents to make child health insurance affordable.[27]

- *Improved Medi-Cal provider payments would address cost-shifting.* As discussed, data suggest that Medi-Cal has significantly underpaid for services for an extended period of time. By bringing Medi-Cal into closer alignment with the payment rates of other insurance providers in California, it would be possible to reduce the need for cost-shifting from the underinsured. By expanding Medi-Cal coverage, it is also possible to decrease the level of cost-shifting because there would be fewer uninsured.

- *Covering the uninsured will require new funds.* As this paper shows, significant money is already spent on the uninsured. However, there will be barriers and challenges in redirecting the savings from the spending on the uninsured, as described in this paper, to the purchase of coverage for these same individuals and families.

- *The private insurance system is increasingly precarious.* Rising health insurance premiums will continue to drive up the number of uninsured in California, which will continue to drive up the cost of insurance premiums due to cost-shifting. As a result, the trend of employers reducing and eliminating coverage will likely continue, creating a vicious cycle that weakens our entire health care system. Other factors at work to reduce insurance coverage—such as financial pressure on employers to reduce benefits in the face of global competition—will only make this phenomenon worse.

The need for political leadership in California is clear. If health care reform was easy, or free, it would have happened already. This paper discusses cost-shifting, which is just one more example that our current health care system is not a system at all. The opportunity costs of continuing our current "system" are staggering. Too many go without the care they need and deserve. Unless real change is made soon, the individual health of Californians, and the health of our economy, will continue to be at growing risk.

## ABOUT THE AUTHORS AND THE NEW AMERICA FOUNDATION

Peter Harbage is a Senior Program Associate with the New America Foundation, and he is also President of Harbage Consulting, a Sacramento-based health policy consulting firm. Len M. Nichols is the Director of the New America Foundation's Health Policy Program. Before joining New America, Dr. Nichols was the Vice President of the Center for Studying Health System Change.

The purpose of the New America Foundation is to bring exceptionally promising new voices and new ideas to the fore of our nation's public discourse. Relying on a venture capital approach, the Foundation invests in outstanding individuals and policy solutions that transcend the conventional political spectrum. The Foundation is a non-partisan and non-profit think tank, with offices in Sacramento and Washington, DC. In its first 14 months, New America's California-based staff and Fellows have published more than 100 articles in all of California's leading newspapers and many key national publications.

## ENDNOTES

[1] Institute of Medicine, *Care Without Coverage: Too Little, Too Late* (Washington: National Academy Press, 2002); Institute of Medicine, *Coverage Matters: Insurance and Health Care* (Washington: National Academy Press, 2001); Jack Hadley, *Sicker and Poorer: The Consequences of Being Uninsured, A Review of the Research on the Relationship between Health Insurance, Health, Work, Income and Education* (Washington: Kaiser Commission on Medicaid and the Uninsured, May 2002).

[2] The $1,186 and $455 amounts represent the total amount of the insurance premium that is the result of cost-shifting—both the employer and employee share. As economists generally believe that the total cost of any health care premium represents a

reduction in employee wages, this paper makes no distinction in the employer and employee share of premiums. The total impact of cost-shifting ultimately falls on the family or individual only.

[3] Brown, Rick and Shana Lavarreda, *Job-based Coverage Drops for Adults and Children but Public Programs Boost Children's Coverage*, UCLA Center for Health Policy Research, February 2005.

[4] Brown, SA Lavarreda, T Rice, JR Kincheloe, MS Gatchell. *The State of Health Insurance in California: Findings from the 2003 California Health Interview Survey*. Los Angeles, CA: UCLA Center for Health Policy Research, 2005.

[5] Based on the population encompassing ages 0 to 64; California HealthCare Foundation, "Health Care Marketplace 2005," and Employer Benefits Research Institute analysis of Census Bureaus 2005 March Supplement.

[6] Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America*, National Academy of Sciences, 2003.

[7] Institute of Medicine, *Coverage Matters: Insurance and Health Care* (Washington: National Academy Press, 2001); Fairbrother, Gerry and Arfana Haidery, *NAF Health Policy Issue Brief: How Health Insurance Stability Impacts the Quality of Health Care*, November 2005.

[8] Calculation: 20 percent uninsured multiplied by 40 percent of the level of care equals 8 percent. In 2004, total health care spending in California was $169 billion, per: California HealthCare Foundation, *Snapshot: California Addendum, Health Care costs 101*, 2006. For purposes of this paper, this spending is grown forward at 8.5 percent.

[9] *Research Findings #27: Health Care Expenses in the United States, 2000*. April 2004. Agency for Healthcare Research and Quality, Rockville, MD. http://www.meps.ahrq.gov/data_files/publications/rf21/rf21.shtml.

[10] Kominski GF, Roby DH, *Estimating the Cost of Caring for California's Uninsured*. Los Angeles: UCLA Center for Health Policy Research, 2004. Also See: Kominski GF, Roby DH, *Cost of Insuring California's Uninsured*, Los Angeles: UCLA Center for Health Policy Research, 2005.

[11] *Research Findings #27: Health Care Expenses in the United States, 2000*. April 2004. Agency for Healthcare Research and Quality, Rockville, MD. http://www.meps.ahrq.gov/data_files/publications/rf21/rf21.shtml.

[12] Kominski GF, Roby DH, *Estimating the Cost of Caring for California's Uninsured*. Los Angeles: UCLA Center for Health Policy Research, 2004.

[13] $9.6 billion is 60 percent of $16 billion.

[14] For a national review of cost-shifting, please see: FamiliesUSA, *Paying a Premium: The Added Cost of the Uninsured*, June 2005. Cost-shifting is discussed in: Institute for Health Policy Solutions, *Covering California's Uninsured: Three Practical Options*, October 2006.

[15] This assumes that all the cost-shifting burden manifests itself a premium increase. Determining how payors react to costs is beyond the scope of this paper.

[16] We derive 10 percent this way: 8 percent of spending on the uninsured, 60 percent of which is shifted, so 4.8 percent of total spending must be shifted. The 55 percent estimate of privately financed health spending includes the ex-post cost-shift, so the actual base to which costs are shifted is 55 percent - 4.8 percent or 50.2 percent. 10 percent is the rounded fraction of 9.6 percent = 4.8 percent / 50.2 percent.

[17] Downloaded from statehealthfacts.org on December 17,2006. Also see: California HealthCare Foundation and Center for Health System Change, *California Employer Benefits Survey*, 2006.

[18] Jack Hadley and John Holahan, *The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?* Issue Update (Washington: Kaiser Commission on Medicaid and the Uninsured, May 10, 2004). See also: Jack Hadley and John Holahan, *How Much Medical Care Do the Uninsured Use, and Who Pays For It?* Health Affairs, Web Exclusive, February 12, 2003.

[19] These are payments to hospitals that are based on formulae that include the number of uninsured patients treated.

[20] These are payments to hospitals based on the number of medical residents they employ.

[21] The Census Bureau, which providers official estimates of the number of uninsured, does not count veterans and Native Americans as being insured just because of their status, since while they have special access to specific service providers in specific locations, they cannot use that access to pay private providers for "covered" services generally. If veterans or Native Americans have private or public insurance, like Medicaid or Medicare, then they are counted as insured, just like other similarly insured residents of the United States.

[22] This spending largely finances the placement of health professionals in medically underserved areas. They typically charge nominal sliding scale fees to their patients, who are often but not always uninsured.

[23] *On the Brink: How the Crisis in California's Public Hospitals Threatens Access to Care for Millions*, California Association of Public Hospitals, 2003.

[24] Allen Dobson, Joan DaVanzo, and Namrata Sen *The Cost-Shift Payment 'Hydraulic': Foundation, History, And Implications*, Health Affairs, January/February 2006; 25(1): 22-33.

[25] Stephen Zuckerman, Joshua McFeeters, Peter Cunningham, and Len Nichols Trends: Changes In Medicaid Physician Fees, 1998-2003: Implications For Physician Participation Health Affairs Web Exclusive, June 23, 2004.

[26] Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America*, National Academy of Sciences, 2003.

[27] Len Nichols, Peter Harbage, and Cindy Zeldin. Shared Responsibility to Cover California's Children: A Key Step on the Road to Universal Health Insurance, California Working Paper #1, November 2005.